

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD01-0213	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2007
NAME OF PROVIDER OR SUPPLIER SIBLEY MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 5255 LOUGHBORO RD NW WASHINGTON, DC 20016		
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H 000	Initial Comments A licensure survey was conducted from January 22 through February 1, 2007. The following deficiencies were cited based on policy review, observations, record and log review.	H 000			
H 003	2000.3 Hospitals In the absence of requirements in this chapter or in other applicable regulations, the management and operation of any hospital shall be in accordance with good medical and public health practices. This CONDITION is not met as evidenced by: 1. Based on the review of records, observation, and confirmation by staff, it was determined that the hospital failed to perform blood cultures in accordance with its blood bank policies and procedures and in accordance with good medical and public health practices. The findings include: Review of the blood bank procedure (#510) conducted on February 1, 2007, culture of the unit is to be initiated when: (1) the patient experience a temperature rise of 2° C (4°F or more; (2) the patient experience " chills " . Regardless of the presence of fever; (3) the patient experience a drop in blood pressure of 20 mmHg or more either the systolic (upper value) or diastolic (lower value), regardless of the presence or absence of fever or chills; and when there is hemolysis in a unit of RBCs. There was no evidence that the laboratory had performed cultures on the units of blood for the following six (6) of the seven (7) transfusion work	H 003			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

O62R11

If continuation sheet 1 of 24

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H 003	<p>Continued From page 1</p> <p>up records reviewed.</p> <p>Patient # 77 had chills with pre- transfusion temperature 96.5° and post- transfusion temperature 102.4°</p> <p>Patient #78 had chills with pre- transfusion temperature 98.4° and post- transfusion temperature 102.9°</p> <p>Patient #79 had chills with pre- transfusion temperature 96.0° and post- transfusion temperature 100.1°</p> <p>Patient #80 had chills with pre- transfusion temperature 99.0° and post- transfusion temperature 100.5°</p> <p>Patient # 81 had chills with pre- transfusion temperature 98.0° and post- transfusion temperature 98.2°</p> <p>Patient #82 had chills with pre-transfusion temperature 98.2° and post- transfusion temperature 98.9°</p> <p>Interview with the blood bank supervisor on February 1, 2007 at approximately 11:00 AM confirmed the aforementioned findings.</p> <p>2. Based on record review and staff interview for an isolated closed record, it was determined that the Emergency Department (ED) staff failed to properly assess, evaluate and manage a major trauma victim. Patient # 52.</p> <p>The findings included:</p>	H 003			

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H 003	<p>Continued From page 2</p> <p>Patient # 52 was transported to the ED on July 16, 2006 following a Motor Vehicle Accident (MVA). According to documentation from the Maryland Ambulance Information Systems record, Patient # 52 was an unrestrained front-seat passenger whose vehicle left the roadway, flipped over a guard rail and landed in a creek among rocks. There was no description of the speed of the vehicle or the distance of the fall. The patient was reportedly ejected from the vehicle, loss consciousness, and awoke some time later on the rocks. Ambulance personnel reported major damage to the front and sides of the vehicle with air bag deployment. The patient's initial injuries were reported as multiple abrasions to the chest, arms and back; and two (2) lacerations to the left lower back. Ambulance documentation also indicated that the area's Level One (1) trauma center was on "trauma bypass".</p> <p>According to the Emergency Department's established Nursing Documentation Guidelines policy, the following directives were included: "Timely, accurate and quality documentation of observations, interventions and teachings provided to patients seeking care in the ED is essential to ensuring that a standardized level of written record is available to support the care provided. In addition, complete documentation will assist in complying with regulatory guidelines and provide supporting evidence of what was done for the patient. As an integral part of the provision of nursing care to patients, documentation must meet minimum standards that are based on nationally recognized and department specific expectations."</p> <p>Under the section of the documentation guidelines subtitled "Evaluation and</p>	H 003			

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H 003	<p>Continued From page 3</p> <p>Management", the following was included: "The initial systems' assessment will be completed by the primary nurse or triage nurse; Systems are evaluated based upon the patient's presenting chief complaint and significant medical history; If a body system is assessed in any part, all items are to be assessed and appropriately documented; A nursing narrative is required for any pertinent information that does not have a specific area elsewhere on the form; and, Any patient given a medication, regardless of route, will remain in the department for a minimum of 20 minutes before being discharged."</p> <p>Furthermore, because the patient had a documented history of loss of consciousness and multiple injuries following a major trauma event, and may have been further cognitively compromised by the presence of alcohol: the subsection of " " Altered Mental Status" under 'Special Cases' Guidelines specifically directed the following: "Document level of consciousness initially and periodically, as needed or changed, during the patient stay; Document items in the neurological systems assessment section; Document the presence of any unusual smells emanating from the patient, describe, do not make assumption; and Complete the psychological system assessment section."</p> <p>Review of the Triage Assessment policy revealed that patient's admitted as major trauma victims were to have continuous, on-going monitoring and reassessments performed to closely evaluate and assess for changes in critical status.</p> <p>ED record review revealed the following findings:</p> <p>Despite the detailed history of major trauma by mechanism and injury given by the Maryland</p>	H 003			

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H 003	<p>Continued From page 4</p> <p>ambulance personnel, ED staff failed to perform a comprehensive and detailed head-to-toe systems assessment and evaluation of the patient to determine and monitor for subtle and/or life-threatening injuries. There was no documented evidence in either the initial ED physician note or the nurse's note that a complete neurological assessment and evaluation was performed to include pupillary sizes and responses.</p> <p>Additionally, staff failed to provide continual hemodynamic monitoring and reassessment of the patient involved in a major trauma event. Nursing note documentation revealed that the patient was "very anxious, agitated. Smells of ETOH (alcohol), admits to ETOH ...had positive loss of consciousness ..." However, there was no evidence that the patient's vital signs were repeated or monitored apart from the initial measurements obtained during triage; and no evidence that the patient was neurologically reassessed or monitored for possible change in condition as a result of his/her blunt head trauma.</p> <p>The patient was subsequently evaluated by the ED physician, had radiological studies performed and was discharged from the ED via security escort. There was no documented evidence that the physician ordered an initial series of diagnostic laboratory studies specific for patients involved in major trauma incidences. Additionally, it was noted that the Head CT Scan initially ordered and performed on the patient was not inclusive of or utilized the specific technique employed for a complete diagnostic evaluation and determination of possible life-threatening injuries. The initial Head CT technique performed was that of a "Spiral CT". The documented technique of use in the second Head CT</p>	H 003			

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H 003	<p>Continued From page 5</p> <p>performed, which confirmed the patient's life-threatening brain injury, was that of "Axial Sections".</p> <p>Upon discharge, the patient briefly returned to the ED "requesting pain med. Motrin P.O. (by mouth) to go given. Patient escorted to bus stop by security." There was no evidence that the patient was reassessed for pain related to trauma injuries, neither was there a corresponding physician's order found to support the administration of the Motrin.</p> <p>According to further review, approximately one-half (1/2) hour after leaving the ED, the patient apparently became unresponsive at the bus stop, and was rushed back to triage by the security guard in a wheelchair. According to triage policy, the patient should have been taken to the main ED immediately for assessment and treatment. However, documentation revealed that the physician was called to the triage area to assess the patient.</p> <p>The patient was discovered to have an acute traumatic brain injury with bleeding. The patient was subsequently moved to the main ED and intubated by the ED physician to establish an emergency airway. Advanced life support measures were then initiated. A repeat radiological study revealed and confirmed that the patient had a life-threatening brain injury. The patient was eventually stabilized for transported by helicopter to a Level 1 trauma center for acute neurosurgical intervention and management.</p> <p>A face-to-face interview was conducted with the ED nurse manager on January 25, 2007 at approximately 3:00 PM. He/she reviewed the record and acknowledged that staff failed to</p>	H 003			

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H 003	Continued From page 6 properly assess, monitor, and evaluate a major trauma victim. The record was reviewed January 25, 2007.	H 003			
H 054	2100.2 Hospitals The governing body shall do the following: (a)Appoint an individual who shall be responsible for the administration of the hospital according to the requirements of this chapter and the policies and directives of the governing body; (b)Adopt administrative policies and rules for the operation of the hospital; (c)Establish a medical staff composed of physicians and other allied practitioners who accept the responsibility for the medical and dental care of the patients; and (d)Required the medical staff to be organized with a chief of staff, president, or chairperson, and to be governed by written bylaws. This CONDITION is not met as evidenced by: 1. Based on medical record review it was determined that the nursing staff and respiratory staff failed to follow the physician order for respiratory therapy. The findings include: A. Patient #71 was admitted on January 19, 2006 with a diagnosis of Dyspnea. Review of the medical record revealed that in January 24, 2007 at 9:00 AM the physician ordered " duo nebs 4 times daily. " The patient care summary report reflected that a treatment was done at 11:45 AM on January 24, 2007 and not again until and 7:55 AM on January 25, 2007. There was no	H 054			

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H 054	<p>Continued From page 7</p> <p>explanation for the time lapse in treatment.</p> <p>B. Patient #74 was admitted on January 22, 2007 with a diagnosis of Bronchitis. Review of the medical record revealed that on admission the physician ordered " oxygen to maintain sats greater than 92% and Atrovent Nebbs around the clock every 6 hours. No oxygen if saturation level is greater than 92%. "</p> <p>Review of the patient care summary report revealed that on January 23, 2007 at midnight and 4:00 AM the nurse documented oxygen saturation levels at 94% and 95% on 2 liters of oxygen. The record does not reflect that the oxygen rate was adjusted downward to oxygen sat levels of 92%.</p> <p>On January 23, 2007 at 8:15 AM the nurse documented that the patient was 87% on room air and 95% on 2.5 liters of oxygen. Additionally, the nurse called for a neb treatment as the patient had " coarse rhonchi and wheezing. " At 3:30 PM on January 23, 2007 (6 hours later) the respiratory therapist documented a treatment while noting that the patient was tachypnea, short of breath and mildly confused on 2 liters of oxygen with sat of 90 to 91%.. There was no explanation for the time lapse in treatment. The subsequent treatments were done at 8:30 PM and then at 4:20 AM, 7:20 AM, 3:55 PM on January 24, 2007 and on January 25, 2007, at 740 AM and 11:45 AM.</p> <p>C. Patient #75 was admitted on January 17, 2007 with a diagnosis of Dyspnea and Pleural Effusion. Review of the medical record revealed that the initial physician order was for 3 liters of oxygen by nasal cannula. ' Review of the detailed patient chart summary revealed that the</p>	H 054			

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H 054	<p>Continued From page 8</p> <p>patient's oxygen level was decreased to 2.5 liters of oxygen, then to 2 liters on January 18, 2006 at 3:00 PM and January 19, 2007 at 8 AM, January 21, 2007 at 9: 00 AM, 3:30 PM, ND 4:58 PM. Additionally, on January 22, 2006 at 9:30 PM , January 23, 2007 at 7:00 AM and 4:00 PM the oxygen level remained at 2:00 PM without a physician ' s order.</p> <p>D. Patient #76 was admitted on January 20, 2007 with a diagnosis of Leccomysarcoma. Review of the medical record revealed that on admission the physician ordered " oxygen at " 4 liters titrate to keep sat at least 94%. " Review of the detailed patient chart summary report revealed that on October 20, at 8:00 PM, October 21, 2007 at 3:00 PM and January 23, 2007 at 3:00 PM the patient oxygen level dropped below 93% without documentation in the vitals signs section and/or narrative that the patient was placed on oxygen at that time.</p> <p>2. Based on record review and interview it was determined that the medical record was completed within 30 days of discharge and all medical information was included in the closed record.</p> <p>The findings include:</p> <p>The medical record has handwritten and computerized entries. Closed Records requested for review during the survey were found to be incomplete. Follow-up interview with the HIM supervisor revealed that the initial medication reconciliation form is a computerized form. HIM staff did not have computer clearance to print the forms for review. Computerized Forms obtained by other staff lacked authentication via the physician and/or nurse signature.</p>	H 054			

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H 054	<p>Continued From page 9</p> <p>A. Patient #58 discharged on December 2, 2006 lacked a signed operative summary in the chart.</p> <p>B. Patient #59 was discharged on December 2, 2006 lacked discharge instruction signed by the physician. Additionally there was no record of the initial medical reconciliation form in the chart for review.</p> <p>C. Patient #60 transferred to another hospital on December 5, 2006 lacked a discharge summary and/or transfer note in the chart for review.</p> <p>D. Patient #61 was discharged on November 8, 2006. The discharge summary was not completed until December 27, 2006.</p> <p>E. Patient #62 was discharged on December 3, 2006. The discharge summary was written but had not been signed by the physician.</p> <p>F. Patient #83 was discharged December 1, 2006. The discharge summary was signed on January 8, 2006. The initial medication reconciliation form was not in the record for review.</p> <p>G. Patient #86 was discharged on December 1, 2006. There was no medication reconciliation in the chart for review.</p> <p>H. Patient #87 was discharged on December 5, 2006. There were no discharge instructions in the chart for review.</p> <p>3. Based on policy and complaint log it was determined that the administrative staff failed to comply with their grievance and complaint policy.</p>	H 054		

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H 054	<p>Continued From page 10</p> <p>The findings include:</p> <p>Policy titled Complaint and Grievance Process revised, September 2006, stipulated the following:</p> <p>The patient care representative will document a grievance which will be entered into the complaint data base. The patient care representative will submit a copy of the complaint to the appropriate department director to inform them of the grievance and request follow-up. Documentation of the investigation is maintained and outcomes will be reported to the quality council.</p> <p>Review of the complaint log from September 2006 to January 2007 on January 24 and 25, 2006 revealed that several complaints were pending investigation and/or documentation of the findings and date of closure.</p> <p>A. Review of complaints filed on September 14, (2), September 17, 2006, November 9 and 22, 2006 revealed the quality council staff had contacted the appropriate Department Head for follow-up. Further investigation revealed that letters had been sent to the patient regarding the investigation outcome by the department head. The quality council staff were not provided with a copy of the follow-up investigation letter and/or findings, thus they were unable to update and do trending analysis. Interview with the Department Head indicated that they were not aware that the letters were to be forward copies of the coorespondence to quality council.</p> <p>B. Patient complaint dated September 28, 2004 was sent for physician peer review on October 18, 2006. Follow-up interview with Medical Director on January 25, 2006 revealed that the</p>	H 054			

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H 054	<p>Continued From page 11</p> <p>case never went to peer review. The Medical Director reported that after consultation with the physician involved it was determined by him/her that the patient did not have a complaint. No letter was ever forwarded to the complainant regarding the decision to not investigate the complainant nor was the quality council staff aware of the decision.</p> <p>C. The complaint log had several complaints isolated to one unit. There was no documentation provided regarding any initiative taken by the unit to increase patient satisfaction.</p> <p>4. Based on incident report and meeting minutes it was determined that the hospital failed to follow-up on actions taken after a sentential event, near miss and/or root case analysis or adress other safety and/or quality concerns.</p> <p>The findings include:</p> <p>Policy 02-25-10 titled Sentinel Events stipulates that the sentinel event review team will conduct the root cause analysis using a sysytematic method, develop the risk reduction plan. coordinate with education and training to develop an inservice and instructional program and present a report of the findings to the Quality Council.</p> <p>Policy 03-25-27 titled Occurence Reporting stipulates that the reporting system is management tool to identify risk factors related to safety. The Department Head shall prepare documentation to specify the corrective actions on the follow-up portion of the occurence form.</p> <p>A. During the review of the Radiation Safety Committee Minutes, on January 23, 2006 it was noted in the minutes of September 25, 2006 that</p>	H 054			

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H 054	<p>Continued From page 12</p> <p>an incident occurred in which a surgical assistant was required, during fluoroscopy, to hold the limb of an orthopedic surgery patient. The assistant, who did not have all the required elements of shielding, expressed concern but was required to carry out the procedure.</p> <p>A short narrative, from the Radiation Safety Officer (RSO), of the incident was submitted to the Radiation Safety Committee (RSC) lacked: a date, reference to an incident report, or follow-up actions, but did contain the names of the staff and physician involved.</p> <p>Review of the policies in radiology revealed that there were specific policy addressing exposure. The incident was discussed by the RSC, and three conclusions/corrective actions were decided - (1) the surgical assistant could have refused to participate in the activity; (2) the surgery department should be stocked with the required elements of shielding to include lead gloves and thyroid shields, and that these things should be available to staff as required; and (3) the RSO would investigate credentialing of non radiologist physicians regarding the use of fluoroscopic radiography equipment, and the re-institution of radiation monitoring of the surgical staff.</p> <p>The RSC meeting minutes of November 17, 2006 included documents to support the study of credentialing non-radiology physicians. No further investigation, or corrective action or follow-up was noted.</p> <p>The RSO, was interviewed by the coordinator of the survey team in regards to the corrective actions and their follow-up. He was not able to give any definitive answer regarding whether there was a follow-up meeting with the staff regarding the proactive and availability of the lead gloves. Before the conclusion of the survey, the surgical suite had received a supply of lead</p>	H 054			

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H 054	<p>Continued From page 13</p> <p>gloves, and the re-institution of dosimetry for their staff was being discussed.</p> <p>B. After a sentential event regarding a dialysis patient in 2006 a communication log was set up between the dialysis staff and unit nurses. According to the renal manager and one unit manager interviewed, on day two and three of the survey, the form had been used for about six (6) months, however neither the renal manager nor the unit manager could provide documentation regarding when the form was placed into service. Additionally, there was no documentation of the in-service provided on how to use the form and the results of any evaluation of the form. On the days of the survey the form was found to be used inconsistently before and after each dialysis treatment.</p> <p>C. An incident occurred, wherein there was a problem with specimen collection in the Cysto Room with the Surgical Physician Assistant (SPA) and the OR staff. A root cause analysis was done and it was recommended that an in-service and/or training be conducted for the Surgical Physician Assistant (SPA) staff within a specific time frame. Follow-up could not be ascertained as the information provided on January 25, 2006 regarding the inservice did not include a sign in sheet, objectives, and verification of competency. Additonally, the content information provided did not address specimen collection.</p> <p>1. Based on medical record and policy review and staff interview it was determined the nursing staff failed to follow the hospital policy #03-31-32 regarding discharge documentation and instructions in four (4) of eight (8) records reviewed for Women and Infant Services (WIS).</p>	H 054			

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H 054	<p>Continued From page 14 (Patients #21, 23, 25, and 28).</p> <p>The findings include:</p> <p>Policy #03-31-32 titled "Charting/Documentation in the Medical Record" section two (2) stipulated "A note is written in the patient's medical record upon discharge, transfer, when patient leaves the nursing unit for a procedure (O.R. invasive procedure) ... This documentation includes a summary of the patient's condition, status of the Patient/Family Education Plan, disposition and mode of transportation ... Documentation should include any discharge instructions given to the patient/and or family and acknowledgement of the information presented."</p> <p>Nursing Addendum to Policy 03-31-32, section titled "Discharge/Transfer Documentation stipulated: "On discharge, the following documentation must be completed..." Discharge Instructions. Refer the reader to the Discharge Instructions Sheet which is given to the patient/family and a copy of which should remain in the permanent record. Details of this instruction need not be documented in the electronic record."</p> <p>A. Patient #21 was admitted on January 4, 2006 for a repeat cesarean section and discharged on January 8, 2007. The record review revealed the lack of documented evidence of a discharge instruction sheet or Discharge Record by January 24, 2007 the review date.</p> <p>B. Patient #23 was admitted on January 3, 2007 for a repeat cesarean section and discharged on January 7, 2007. The record review revealed the lack of documented evidence of a discharge instructions sheet by January 25, 2007 the review</p>	H 054			

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H 054	<p>Continued From page 15 date.</p> <p>C. Patient #25 was admitted on January 2, 2007 with a diagnosis of Pregnancy full-term status post a vaginal delivery and discharged on January 4, 2007. The medical record lacked documented evidence of a discharge note and/or discharge instruction sheet by January 25, 2007 the review date.</p> <p>D. Patient #28 was admitted on September 1, 2006 with a diagnosis 38 weeks pregnancy with vaginal delivery with a first degree laceration and was discharged on September 3, 2006. The medical record lacked documented evidence of a discharge note and/or discharge instruction sheet by January 25, 2005 the date of review.</p> <p>Interview with the administrative nursing staff for WIS revealed that the patients are given a large amount of patient information and instructions throughout the hospitalization. A "Discharge Record" is started on admission and is completed on discharge. The "Discharge Record is a checklist of all the required information that is given to the mothers from admission to discharge. According to the administrative nursing staff some of the instructions are captured in the Patient Family education record, nursing notes via Affinity and the "Care Note System". The Discharge Record is part of the permanent medical record because the checklist summarized the information and instructions given to the mothers. The administrative staff indicated that the discharge instructions sheet in not a part of the permanent medical record.</p> <p>The Nurse Director for WIS stated a new computer system specifically for obstetrics was being implemented for the WIS. The records</p>	H 054			

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H 054	<p>Continued From page 16</p> <p>were reviewed on Janaury 23, 2007.</p> <p>Note: None of the above medical records contained discharge instructions sheets; three (3) out of the four (4) medical records obtained the "Discharge Record."</p> <p>Medication Reconciliation</p> <p>2. Based on medical record review and staff interview it was determined that the hospital staff failed to follow the policy title Medication Reconciliation and Discharge Medications in two (2) of of six (6) records reviewed for discharge planning.(patients #31,32)</p> <p>The findings included:</p> <p>Policy titled Medication Reconciliation and Discharge Medication stipulated the following: "All patient admitted to Sibley Memorial Hospital will provide as part of the clinical assessment a complete medication history. This medication history will be documented in the hospital computer system under Medication History. A report of the Medication History will be printed and the provider will reconcile the medication history with the admission orders ...The provider will sign the medical history report within 48 hours of writing the admission orders ...When the patient is being discharged, the providers should use the medication administration record and medication history report to generate the most accurate list of medications for the discharge paperwork."</p> <p>A. Patient #31 admitted on December 22, 2006 with a Prostate Cancer. Review of the record revealed that on discharge the provider failed to sign the medication reconciliation record.</p>	H 054			

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H 054	<p>Continued From page 17</p> <p>B. Patient # 32 was admitted on January 2, 2007 with diagnoses of Aortic stenosis associates with Congestive Heart Failure. The record review revealed that on admission the provider did not signed the admission reconciliation record or medication history for the patient.</p> <p>3. Based on record review and staff interview, it was determined that the Emergency Department (ED) staff failed to provide continual hemodynamic monitoring and perform on-going clinical assessments for clinical records reviewed; and failed to monitor and reassess patients for clinical responses and the efficacy of therapeutic treatments administered in three (3) of ten ED records reviewed. (Patients' # 36, 38, and 43)</p> <p>The findings include:</p> <p>According to the "Emergency Department Nursing Documentation Guidelines", most recently amended on July 26, 2005, the following directives were included: "The triage nurse will conduct an assessment and complete the triage portion of the nursing documentation form in a timely manner; The initial systems' assessment will be completed by the primary nurse or triage nurse; Systems are evaluated based upon the patient's presenting chief complaint and significant medical history; if a body system is assessed in any part, all items are to be assessed and appropriately documented; Vital signs are performed and documented a minimum of every 4 hours beyond the initial assessment. They will be done more frequently if the patient condition warrants; a nursing narrative is required for any pertinent information that does not have a specific area elsewhere on the form; and, response to any medications expected to cause a</p>	H 054			

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H 054	<p>Continued From page 18</p> <p>change in the patient's condition during the ED visit must be documented."</p> <p>A. Patient # 36 was admitted to the ED on January 18, 2007 via Emergency Medical Services (EMS) medic unit with a sudden onset of unresponsiveness while at the nursing home. The patient had a previous history of Bitemporal Subarachnoid Hemorrhage in October 2003 and a recent history of Pneumonia.</p> <p>According to documentation in the ED record, the patient arrived awake but oriented to person only; had some respiratory distress with increased work of breathing; and was suffering a cardiac event: Atrial Fibrillation with a rapid ventricular response (a disruption in the normal function of the electrical conduction in the heart causing a rapid or irregular heart beat).</p> <p>Review of the physician's orders and the ED medication administration record revealed that the patient was administered an Intravenous (IV) bolus of Cardizem (antiarrhythmic medication) to correct the heart's rapid, irregular rate. This was followed by a Cardizem IV drip to maintain a regular rhythm.</p> <p>According to pharmacological information contained in the Nursing Spectrum Drug Handbook 2006, the following recommendations and warnings concerning the administration of Cardizem was included: "Withhold dose if systolic blood pressure falls below 90 mm Hg (millimeters of mercury), or apical pulse is slower than 60 beats/minute; Check blood pressure and electrocardiogram (ECG) before initiating therapy, and monitor closely during dosage adjustment period; and monitor for signs and systems of heart failure and worsening</p>	H 054			

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H 054	<p>Continued From page 19</p> <p>arrhythmias)."</p> <p>There was no documented evidence that staff reassessed the patient for hemodynamic stability during the administration of the Cardizem. Nor was there evidence that staff documented and monitored the patient for potential adverse effects, as cautioned in the nursing drug handbook.</p> <p>A face-to-face interview was conducted with the ED nurse manager on January 25, 2007 at approximately 3:00 PM. He/she acknowledged that staff failed to perform on-going clinical assessments and monitor the patient for clinical responses to therapeutic treatments administered (IV Cardizem). The record was reviewed January 22, 2007.</p> <p>B. Patient # 38 was transported to the ED via ambulance stretcher on January 4, 2007. He/she was found lying on the floor of a nursing facility after sustaining an unwitnessed fall. The patient had suffered a hematoma on the back of the head and had an open abrasion. Patient #38 was reportedly agitated after the fall and was exhibiting unusual behavior. There was a questionable loss of consciousness.</p> <p>Past medical history was significant for the following: Hypotension; Hypoglycemia; Advanced Multi-Infarct Dementia; Cerebral Vascular Accident (CVA); and Atrial Fibrillation.</p> <p>A review of the ED nursing triage form revealed that the patient's acuity level and priority of care was classified as "Fastrack" by the triage nurse. This was a non-urgent classification.</p> <p>There was no documented evidence that either</p>	H 054			

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H 054	<p>Continued From page 20</p> <p>the triage nurse or the primary nurse responsible for the patient's care performed a complete neurological assessment on the patient, to include the assessment of pupillary size and responses to light stimuli.</p> <p>There was furthermore no documented physical assessment or description of the patient's head injury by the ED nursing staff. The patient was not monitored or placed on continuing neurological checks to assess for possible changes in levels of consciousness.</p> <p>The patient was subsequently sent to an alternate area of the ED and evaluated by a Physician's Assistant (PA). Record review failed to provide evidence that there was physician supervision or oversight of the PA in the Fastrack area. There was no physician countersignature on the ED record. Nor was there documented evidence of any discussion with the physician concerning the care and management of the patient during the ED visit or prior to his/her release from the ED.</p> <p>A face-to-face interview was conducted with the ED nurse manager on January 24, 2007 at approximately 2:30 PM. He/she acknowledged the above findings. The record was reviewed January 24, 2007.</p> <p>C. Patient # 43 arrived in the ED on January 3, 2007 complaining of a sudden onset of shortness of breath. He/she had medical history significant for Hypertensive Cardiac Disease and Glaucoma.</p> <p>Review of the ED nursing triage form revealed that the patient's acuity level and priority of care was classified as "Urgent". Documentation revealed that the patient was evaluated by a Physician's Assistant (PA) approximately 40</p>	H 054			

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H 054	<p>Continued From page 21</p> <p>minutes after triage.</p> <p>Record review determined the following findings:</p> <p>ED nursing staff failed to document a detailed reassessment of the patient's respiratory system to include lungs sounds, respirations, and respiratory effort. Staff also failed to provide on-going clinical reassessments and documentation pertaining to the hemodynamic stability or instability of the patient. According to the departments reassessment recommendations, patients with assigned triage acuity levels of "Urgent" were to be reassessed "every 2 hours and PRN (as often as necessary)". The patient was on a cardiac monitor and pulse oximeter. Vital signs were not measured or recorded after his/her initial triage until the time of discharge (approximately 5 hours later).</p> <p>Furthermore, record review failed to provide evidence that there was physician supervision or oversight of the PA. There was no physician countersignature on the ED record. Nor was there documented evidence of any discussion with the physician concerning the care and management of the patient during the ED visit or prior to his/her release from the ED.</p> <p>A face-to-face interview was conducted with the ED nurse manager on January 24, 2007 at approximately 2:45 PM. He/she acknowledged the above findings. The record was reviewed January 24, 2007.</p>	H 054			
H 228	<p>2301.2 Hospitals</p> <p>Hospital structures and all facilities in the hospital structure shall be kept in a clean and sanitary condition and in good repair at all times, and the</p>	H 228			

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H 228	<p>Continued From page 22</p> <p>surroundings of each hospital structure shall be kept free from litter and rubbish. This CONDITION is not met as evidenced by: Based on observations made while conducting the environmental survey of six (6) of ten (10) patient units and patient ancillary services, the following patient care units were in need of repair and not maintained in a sanitary manner.</p> <p>The finding include:</p> <ol style="list-style-type: none"> 1. The lower portion of the Venetian blinds are marred or discolored. (patient unit 6 west). The surfaces of the window screens are visibility soiled with an accumulation of dust. (patient unit 6 East) 2. Stained ceiling tiles were observed in the following areas; (a) three (3) tiles were observed stained in room 317 on patient unit 3West; (b) in patient room 311 on 3 West there is one badly stained tile over 1/2 of the surface of the tile; (c) in the fast track area of the ED four (4) stained tiles were observed and two (2) stained tiles were observed in the GYN treatment/exam room-ED. 3. Water was observed leaking from one (1) faucet in patient room 636 and water was observed leaking from the base of the faucet set in room 608 on unit 6 East when both faucet were turned on. In the toilet room located in the corridor of 6 East, the base of the faucet set is encrusted with a build up of lime deposit. A water leak was observed flowing from around the connecting pipe when the flush handle was depressed on the toilet located in the toilet room adjacent to room 607 on patient unit 6 west. 	H 228		

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H 228	Continued From page 23 4. Based on observations made while touring patient unit 7 east, the wall paper was found peeling from the surface of the wall that frames the window in patient room #720.	H 228			

Sibley Memorial Hospital
Patient List
January 22 to 25, 2007

Patient 01	Lydna Lovett	SCC
Patient 02	Cathy L-Painter	Endoscopy
Patient 03	Anthony Koones	Endoscopy
Patient 04	Sheila Myer	Endoscopy
Patient 05	James Barrett	Endoscopy
Patient 06	Vicky Bailey	Endoscopy
Patient 07	Chulum Abbas	Perioperative Services
Patient 08	Tamara Barros	Perioperative Services
Patient 09	Barbara Abrishamion	Perioperative Services
Patient 10	Micheal Carlo	Perioperative Services
Patient 11	Stacy Thieme	Perioperative Services
Patient 12	Richard Eury	Cardiology Outpatient
Patient 13	Natasha Haubold	3 East
Patient 14	Charlotte Haubold (A)	SCN
Patient 15	Vanessa Haubold (B)	SCN
Patient 16	Babygirl Halvasor	SCN
Patient 17	Katherine Herman	3-East
Patient 18	Babyboy Herman	3-East-Nursery
Patient 19	Laurie Cynkin	WIS
Patient 20	Babygirl Cynkin	WIS
Patient 21	Judy Taylor Fisher	WIS
Patient 22	Babyboy Taylor	WIS
Patient 23	Jennifer Arceneaux	WIS
Patient 24	Babyboy Arceneaux	WIS
Patient 25	Lynn Haaland	WIS
Patient 26	Babyboy Haaland	WIS
Patient 27	Botagoz Panico	WIS
Patient 28	Leanne Dougherty	WIS-grievance review
Patient 29	Kathleen Knight	WIS-Antepartum
Patient 30	Shannon Bowan	GYN/Surgery
Patient 31	John Waugh	Medication Reconcile
Patient 32	Mary Runfola	Cardiology-Medication Reconcile
Patient 33	Stephen Gripkey	Perioperative Service-
Patient 34	Ali Sobalvarro	Perioperative Service-PI review
Patient 35	Joann Naugle	Critical Care Center
Patient 36	Sarah Brooks	Critical Care Center
Patient 37	Shulamith Hochstein	Emergency Department (closed)
Patient 38	William Allman	Emergency Department (closed)
Patient 39	Lisa McClaugherty	Emergency Department (closed)
Patient 40	Elizabeth Gobar	Emergency Department (closed)
Patient 41	Demetrius Rice	Emergency Department (closed)
Patient 42	Hans Heymann	Emergency Department (closed)

Sibley Memorial Hospital
Patient List
January 22 to 25, 2007

Patient 43	Peter Ainslie	Emergency Department (closed)
Patient 44	Nancy Silvio	4 East
Patient 45	Lynn Addison	4 East
Patient 46	Lisa Greene	6 East
Patient 47	Veronica Raindrop	6 East
Patient 48	Joy Atherton	Emergency Department
Patient 49	James Elliott	Emergency Department
Patient 50	Mark Ajamian	ICU/IMC
Patient 51	Julian De La Pena	ICU/IMC
Patient 52	John Elwood	Emergency Department (closed)
Patient 53	Rosina Altwegg	4E
Patient 54	Mary Barnhard	4E
Patient 55	Lindsay Kegley	4E
Patient 56	Shirley Heft	5W (dialysis patient)
Patient 57	Jennifer Miller	6E
Patient 58	William Clagett	6E
Patient 59	Lonnie Bennett	6W
Patient 60	Shirley Kotz	5W
Patient 61	Jinny Eury	Endo/Cardio Dept
Patient 62	Alicia Gilbert	6 W
Patient 63	Ruth Hock	ED
Patient 64	Stephen Dahlgren	ED
Patient 65	James Newman	5W restraints
Patient 66	Valerie Cullinane	Focus (specialized procedures)
Patient 67	Eunice Meek	2W OR
Patient 68	Frederick Brott	5W
Patient 69	Yvette Jenkins	5W
Patient 70	Charlene Goldberg	5W
Patient 71	Laverne McIntosh	5E
Patient 72	Gertrude Braxton	6W
Patient 73	Henry Work	6W
Patient 74	Rose Peres	6W
Patient 75	Bruce Mulno	5E
Patient 76	Linda Higgison	5E
Patient 77	Roderick Hills	lab
Patient 78	Selma Cohen	lab
Patient 79	Allye Krawish	lab
Patient 80	Elizabeth Burton	lab
Patient 81	Lois Klinedinst	lab
Patient 82	Carol Joseph	lab
Patient #83	Barbara Coward	5 W
Patient #84	Milton Milverson	CCC

Sibley Memorial Hospital
Patient List
January 22 to 25, 2007

Patient #85	Rosina Atwegg	4E
Patient #86	Mary Barnhard	4E
Patient #87	Lindsay Kegley	4E
Patient 88	Ralph E. King	Interventional Radiology
Patient 89	Jessica Parks	Interventional Radiology
Patient 90	Monserrat B. Munoz	Interventional Radiology
Patient 91	Adam M. Lloyd	Interventional Radiology

Sibley Memorial Hospital

Recommendations

Survey dates January 22 to February 1, 2007

Recommendations

Laboratory Services

1. It is recommended that the hospital's Blood Transfusion Service procedure (#520) for processing Lookbacks be revised to include procedures to maintain evidence of notification in the patient's medical record.

Review of records failed to provide information regarding a procedure to keep a copy of the notification record in the patient's medical record to ensure consistency with the federal regulation notification requirements.

2. It is recommended that the hospital review the staffing need for Microbiology laboratory during the hours of 4:30 PM to 7:00 AM to ensure timely processing of positive blood cultures.

According to the laboratory's blood culture procedure, once a positive culture is suspected (BACTEC positive indicator light on), a Gram stain is made immediately from the suspect bottle. The results of the Gram stain are called to the patient's nurse or doctor as soon as possible. Interview with Microbiology laboratory staff members on January 31, 2007 at approximately 9:30 AM, revealed that there is no assigned staff member between 4:30 PM and 7:00 AM to process positive blood cultures. This section of the laboratory is only staffed between 7:00 AM and 4:30 PM., a positive blood culture bottle that is identified as positive (by the BACTEC machine) at or after 4:30 PM will not be processed until next day.

3. It is recommended that the hospital develop a mechanism to ensure that critical value ranges used by the laboratory for notification purposes are differentiated clearly from the critical value ranges that are flagged as critical on the chartable report. For example, a PTT value of 45.5 seconds is flagged ** with box on the chartable report to indicate that this value is critical. However, only PTT values that are greater than 135 seconds are considered critical by the laboratory. Both PTT values (135 seconds and 45.5 seconds) could be flagged the same way (**with a box) on the laboratory report.

Patient Rights

4. It is recommended for the hospital to develop an effective mechanism for communicating finger stick glucose values among staff to ensure patient confidentiality.

During observation of POCT of unit 3N on January 30, 2007 at approximately 12:05 PM, staff were observed documenting each patient's finger stick glucose on a dry erase board identified by room numbers. This information was very obvious to other patient's visitors and others who do not need to know.

Sibley Memorial Hospital

Recommendations

Survey dates January 22 to February 1, 2007

Patient Safety

5. It is recommended that the hospital administration ensure that the contract agency providing dialysis services comply with the AAMI standard. Review of the monthly water quality log results for 2006 revealed that a water analysis results was found above the AAMI standard of 200 colony counts in September 2006, without the appropriate corrective action taken. Additionally, three (3) machines placed into services on March 2006 lacked documentation of the bi-annual electrical leakage test.

Safe Handling of Supplies

6. It was recommended to staff that all equipment, supply carts, and stretchers be stored along one side of the corridor in order to facilitate easy exiting from each OR in case of an emergency and to expedite easy unobstructed staff and patient traffic flow out of the OR suite in case of an emergency.

Based on observations made while touring the OR, supplies and equipment and stretchers were observed being stored along both sides of the OR corridors adjacent to OR 's. II. Based on observations made while conducting the Environmental tour on patient unit 7 East in the medication/supply room, an Oxygen cylinder was found lying on the floor partially underneath the medication cart versus being securely racked and stored. It was noted that the tag tied to the cylinder indicated " empty; " however, guidelines for the safe handling of full and empty cylinders require that all cylinders be securely racked at all times.

Sibley Memorial Hospital**Observations/****Survey Dates: January 22-February 1, 2007****Observations****Safety and Privacy**

Based on observations made while conducting the Environmental tour of the facility, it was observed that the keys that open the locking mechanism for the door of the corridor restrooms were observed hanging on a chain that was mounted on the outside of the door just below the lock. This was observed on 2 unit-sex corridor restrooms located when the vicinity of the waiting room area of the ED. It was suggested by the surveyor and then corrected by the Maintenance Director, that the keys be removed and placed in the care of the Director of the ED or placed in a secure area within the ED, but easily assessable location.

Infection control

During a previous survey it was brought to the attention of the Director of the Cancer Center the potential risk of contamination when commingling of patient gowns is permitted. During the 2006 and this year, 2007 annual licensure survey observations made revealed patient gowns are being stacked on open shelves in the women's patient change area versus being individually packaged, or being distributed by staff. This method of storage of the gowns does not provide a completely sanitary environment for the storage of the patient gowns. It was recommended again that the facility devise a way to insure there is no commingling of patient gowns. Further, it was noted that the soiled linen collection bin is positioned directly beneath the shelves these gowns are stored on. (Note: all soiled and clean linens are to be stored separately in appropriately designated clean and soiled areas).